



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-08-2133-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the fair and reasonable reimbursement amount for this hospital outpatient admission should be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."

Amount in Dispute: \$1,162.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Adopted Rule 134.401 (b)(2) identifies the type of reimbursement code for this surgery as inpatient surgical. Further, Rule 134.401 (c) provides the reimbursement rate for surgical admissions is \$1,118 per diem. The carrier paid this amount plus an additional \$20.94 for an ECG which was beyond the normal expected medical for this surgical admission. Therefore, the carrier has fully reimbursed the Requestor under the Adopted Rules. The carrier requests that Division issue a findings that the Requestor is not entitled to any further reimbursement."

Response Submitted by: Lewis & Backhaus, PC, 14160 Dallas Parkway 400, Dallas, TX 75254

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2007	Outpatient Surgery	\$1,162.07	\$891.48

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 Texas Register 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. The respondent's position statement asserts that "...this matter more properly falls under Adopted Rule 134.401 and the reimbursement provisions therein." 28 Texas Administrative Code §134.401(b)(1)(B), effective August 1, 1997, 22 Texas Register 6264, defines inpatient services as "Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." Review of the submitted information finds no documentation to support that the length of stay exceeded 23 hours; the Division therefore finds that the services in dispute do not meet the definition of inpatient services. Per §134.401(a)(4) "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements." Therefore, the Division concludes that the reimbursement provisions of §134.401 are not applicable to the services in dispute; the applicable rule for determining fair and reasonable reimbursement for the services in dispute is found in §134.1.
5. This request for medical fee dispute resolution was received by the Division on November 27, 2007.
6. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the Claim Adjudication Process as to the Workers' Compensation Receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 Trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
7. By letter dated May 26, 2011, the attorney for the requestor provided *REQUESTOR'S AMENDED POSITION STATEMENT (RENAISSANCE HOSPITAL – DALLAS)* that specified, in pertinent parts, an "Additional Reimbursement Amount Owed" of \$891.48 and an "alternative" "Additional Reimbursement Amount Owed" of \$661.10. The Division notes that the amount in dispute of \$1,162.07 specified in Part IV above is the original amount in dispute as indicated in the requestor's *TABLE OF DISPUTED SERVICES* submitted prior to the *REQUESTOR'S AMENDED POSITION STATEMENT*.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 176–Modifier 27/TC represents the technical component of service performed
 - 600–Reimbursement based on usual, customary and reasonable for this geographic region
 - ANSI97–97–Payment is included in the allowance for another service/procedure
 - ANSIW10–W10–No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier
 - L01–Recommended allowance is considered fair and reasonable
 - L02–Fair & reasonable based on comparison of services performed & reimbursed in your geographical area
 - L03 – Charge is considered inclusive in the fair and reasonable recommended allowance

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
 - The requestor’s amended position statement asserts that “the fair and reasonable reimbursement amount for this hospital outpatient admission should be commensurate with the average amount paid by all insurance carriers in the Texas workers’ compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code.”
 - In support of the requested reimbursement methodology the requestor states that “Ordering additional reimbursement based on the average amount paid system-wide in Texas achieves effective medical cost control because it prevents overpayment... creates an expectation of fair reimbursement; and... encourages health care providers to continue to offer quality medical care to injured employees... Ordering additional reimbursement for at least the average amount paid for a hospital outpatient admission during the same year of service and involving the same Principal Diagnosis Code and Principal Procedure Code ensures that similar procedures provided in similar circumstances receive similar reimbursement... The average amount paid for similar admissions as put forward by the Requestor is based on a study of data maintained by the Division.”
 - The requestor submitted documentation to support the state-wide, annual, average reimbursement in Texas for the principal diagnosis code and principal procedure code of the disputed services during the year that the services were rendered.
 - The requestor has explained and supported that the requested reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is supported. Thorough review of the submitted documentation finds that the requestor has discussed, demonstrated, and justified that the average amount paid by all insurance carriers in the Texas workers’ compensation system in the same year as the disputed admission for those admissions involving the same principal diagnosis code and principal procedure code is a fair and reasonable rate of reimbursement for the services in dispute.

2. In the alternative, the requestor proposes that “it is justifiable to order additional reimbursement under the Hospital Facility Fee Guidelines – Outpatient because the Division’s new fee guidelines, while not in effect at that time, are presumptively fair and reasonable reimbursement under the law and data from the Medicare Outpatient Prospective Payment System for this date of service is available for calculating the amount due.” Review of the submitted documentation finds that:
 - In support of the alternative requested reimbursement methodology the requestor states that “The data necessary to calculate the Maximum Allowable Reimbursement for this year of service is readily available from the Medicare Outpatient Prospective Payment System. Therefore, the new fee guidelines as adopted in 28 TEX. ADMIN. CODE § 134.403 provide a presumptive measure for the fair and reasonable reimbursement amount.”
 - The requestor did not submit documentation to support the Medicare payment calculation for the services in dispute.
 - The fee guidelines as adopted in 28 Texas Administrative Code §134.403 were not in effect during the time period when the disputed services were rendered.
 - The Division disagrees that the fee guidelines as set forth in §134.403 are “presumptively fair and reasonable reimbursement under the law” for dates of service prior to the date the rule became effective. No documentation was found to support such a presumption under law.
 - While the Division has previously found that Medicare patients are of an equivalent standard of living to workers’ compensation patients (22 Texas Register 6284, July 4, 1997), Texas Labor Code Section 413.011(b) requires that “In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d)... This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services.”
 - The requestor did not discuss or present documentation to support how applying the proposed payment adjustment factors as adopted in 28 Texas Administrative Code §134.403, effective for dates of service on or after March 1st, 2008, would provide fair and reasonable reimbursement for the disputed services during the time period that treatment was rendered to the injured worker.

- The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the alternative requested reimbursement.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for the alternative additional amount of \$661.10 is not supported. The requestor has not demonstrated or presented sufficient documentation to support that the alternative additional amount requested of \$661.10 would provide a fair and reasonable rate of reimbursement for the services in dispute.

3. 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(IV), effective December 31, 2006, 31 TexReg 10314, applicable to requests filed on or after January 15, 2007, requires the respondent to provide a statement of the disputed fee issue(s), which includes: "a discussion regarding how the submitted documentation supports the respondent's position for each disputed fee issue." Review of the documentation submitted by the respondent finds that the respondent has not discussed how the submitted documentation supports the respondent's position for each disputed fee issue. The Division concludes that the respondent has not met the requirements of §133.307(d)(2)(A)(iv)(IV).
4. 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(V), effective December 31, 2006, 31 TexReg 10314, applicable to requests filed on or after January 15, 2007, requires the respondent to provide "documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 of this title if the dispute involves health care for which the Division has not established a MAR, as applicable." Review of the submitted documentation finds that:
 - The respondent's position statement asserts that "Adopted Rule 134.401 (b)(2) identifies the type of reimbursement code for this surgery as inpatient surgical. Further, Rule 134.401 (c) provides the reimbursement rate for surgical admissions is \$1,118 per diem. The carrier paid this amount plus an additional \$20.94 for an ECG which was beyond the normal expected medical for this surgical admission. Therefore, the carrier has fully reimbursed the Requestor under the Adopted Rules. The carrier requests that Division issue a findings that the Requestor is not entitled to any further reimbursement."
 - The respondent did not discuss or explain how the amount paid represents a fair and reasonable reimbursement.
 - The respondent did not submit documentation to support that the amount paid is a fair and reasonable rate of reimbursement.
 - The respondent did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support that the amount paid is a fair and reasonable reimbursement for the services in dispute.
 - The respondent did not explain how the amount paid satisfies the requirements of 28 Texas Administrative Code §134.1.

The respondent's position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute. The Division concludes that the respondent has not met the requirements of 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(V).

5. The Division finds that the documentation submitted in support of the fair and reasonable methodology proposed by the requestor based on the average amount paid by all insurance carriers in the same year for admissions involving the same principal diagnosis code and principal procedure code as the services in dispute is the best evidence in this dispute of an amount that will achieve a fair and reasonable reimbursement for the services in this dispute. Reimbursement will therefore be calculated as follows. Review of the medical bill finds that the principal diagnosis code for the disputed services is 726.0. The principal procedure code is 93.26. The requestor submitted documentation to support that the average, state-wide reimbursement for this diagnosis code and procedure code performed in 2007 was \$2,030.42. This amount less the amount previously paid by the respondent of \$1,138.94 leaves an amount due to the requestor of \$891.48. This amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the requestor has established that additional reimbursement is due. The Division concludes that the carrier's response was not submitted in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the respondent failed to support that the amount paid by the insurance carrier is a fair and reasonable reimbursement in accordance with Division rule at 28 Texas Administrative Code §134.1. As a result, the amount ordered is \$891.48.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$891.48 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Margaret Q. Ojeda
Medical Fee Dispute Resolution Officer

September 15, 2011
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.